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## **HIPAA Authorization**

I, \_\_\_\_\_, give permission for

\_\_\_\_\_  
(Name)

\_\_\_\_\_  
(Relationship)

\_\_\_\_\_  
(Name)

\_\_\_\_\_  
(Relationship)

to discuss my medical information and to request and pick up my prescriptions for me in my absence. This consent is to be in effect until I notify the health department otherwise.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date